DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

APPLICATION FOR EVIDENTIARY HEARING

3315 West Truman Blvd.
P.O. Box 58
Jefferson City, MO 65102-0058

Pursuant to 8 CSR 50-2.030(1)(I), this form shall be used if the total amount of the additional reimbursement sought is more than one thousand dollars ($1,000), or this form may also be used to request an evidentiary hearing by any party aggrieved by the Division Director's Administrative Ruling, in a case where the additional reimbursement sought was $1,000 or less.

_____,)
Health Care Provider,)
)
vs.)
)
_____,) Employee (Patient): _____
Employer,)
)
and)
)
_____,)
Insurer)

Medical Fee Dispute No: ____-_____

DWC Injury No.: ____-_____

Date of Accident/
Occupational Disease: _____

APPLICATION FOR EVIDENTIARY HEARING

The undersigned party hereby applies to the Division of Workers' Compensation for an evidentiary hearing in the above captioned case.

☐ Health Care Provider Name _____

☐ Employer Name _____

☐ Insurer/Third Party Administrator Name _____

Respectfully submitted, _____

Name of Attorney _____

Law Firm _____

Address _____

Bar No. _____

Phone No. _____

Fax No. _____

E-mail Address _____

CERTIFICATE OF SERVICE

I, the undersigned, certify that a true and accurate copy of this Application for Evidentiary Hearing has been mailed or hand delivered to all attorneys and/or all parties of record this _____ day of _____, 20____.

Attorney's Signature _____ Date _____

Attorney's Name *(Printed)* _____ Bar No. _____

Address *(if different than above)* _____

DIVISION USE ONLY

DATE STAMP

*** Please be advised that corporations and limited liability companies appearing before the Division must be represented by an attorney licensed in the State of Missouri. See *Reed v. Labor and Ind. Rel. Commn.*, 789 S.W.2d 19, 20 (Mo. banc 1990).**

*** If the Health Care Provider is a corporation or a LLC, and this Application is not signed by an attorney, this Application will be rejected.**